

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
04-006

2. STATE
South Carolina

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2004

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447

7. FEDERAL BUDGET IMPACT: See Attachment

a. FFY 2004 \$31
b. FFY 2005 \$1.22

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19-A - Pages 4,5,32,39, and 40
4.19-B - Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):
4.19-A - Pages 4,5,32,39, and 40
4.19-B - Page 1

10. SUBJECT OF AMENDMENT:
Retrospective Medicaid inpatient and outpatient cost settlements for qualifying hospitals with burn intensive care units.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//Robert M. Kerr-signature//

13. TYPED NAME:
Robert M. Kerr

14. TITLE:
Director

15. DATE SUBMITTED:
August 18, 2004

16. RETURN TO:
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
October 12, 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis G. Smith

21. TYPED NAME: DENNIS G. Smith

22. TITLE: Director, CM SO

23. REMARKS:

inclusive rate. Each facility's per diem rate will be calculated using base year data trended forward. Section V B describes the rate calculation.

15. Effective October 1, 1998, reimbursement for statewide pediatric telephone triage services will be available for the designated South Carolina Children's Hospitals. Payment will be based on the Medicaid portion of allowable service cost.
16. Effective October 1, 1999, a small hospital access payment will be paid to qualifying hospitals that provide access to care for Medicaid clients.
17. Effective October 1, 2000, hospitals participating in the SC Universal Newborn Hearing Screening, Detection, and Early Intervention Program will be reimbursed for Medicaid newborn hearing screenings. Effective July 1, 2001, all hospitals will be eligible for this reimbursement.
18. Effective for admissions on or after October 1, 2001, hospitals will be reimbursed for Norplant and Depo-Provera.
19. Effective for admissions on or after January 1, 2004 a standard co-payment amount of \$25 per admission will be charged when a co-payment is applicable.
20. Effective for services provided on or after October 1, 2003, private (i.e. non-public) hospitals that qualify for the SC Medicaid DSH program will receive inpatient retrospective cost settlements that will be limited to 90% of their allowable Medicaid inpatient cost.
21. Effective for services provided on or after July 1, 2004, qualifying hospitals with burn intensive care units will receive annual retrospective cost settlements for the total cost of inpatient services provided to South Carolina Medicaid patients.

SC: 04-006
EFFECTIVE DATE: 07/01/04
RO APPROVAL: OCT 12 2004
SUPERCEDES: MA 03-015

II. Definitions Applicable to Inpatient Hospital and Residential Treatment Facility Reimbursement

The following definitions will help in understanding the payment rates set for inpatient hospital and residential treatment facility services:

1. Administrative Days - The days of service provided to recipients who no longer require acute hospital care, but are in need of nursing home placement that is not available at the time. The patient must meet either intermediate or skilled level of care criteria.
2. Arithmetic Mean (average) - The product of dividing a sum by the number of its observations.
3. Base Year - The fiscal year used for calculation of prospective payment rates. For rates effective October 1, 1993 the base year shall be each facility's 1990 fiscal year. Where 1990 cost reports are not finally audited, an adjustment factor, as described in Section IV of this plan, will be utilized.
4. Burn Intensive Care Unit Cost Settlement Criteria - In order to qualify for this cost settlement a hospital must satisfy all of the following criteria. A hospital must:
 - Be located in South Carolina or within 25 miles of the South Carolina border;
 - Have a current contract with the South Carolina Medicaid Program;
 - Not be a disproportionate share hospital in the South Carolina Medicaid Program; and
 - Have at least 25 beds in its burn intensive care unit.
5. Capital - Cost associated with the capital costs of the facility. For purposes of the prospective payment methodology, capital costs include, but are not limited to, depreciation, interest, property taxes, property insurance, and directly assigned departmental capital lease costs.
6. Case-Mix Index - A relative measure of resource utilization at a hospital.
7. Cost - Total audited allowable costs of inpatient services, unless otherwise specified.
8. CRNA - Certified Registered Nurse Anesthetist.
9. Diagnosis Related Groups (DRGs) - A patient classification that reflects clinically cohesive groupings of patients who consume similar amounts of hospital resources.
10. Direct Medical Education Cost - Those direct costs associated with an approved intern and resident or nursing school teaching program as defined in the Medicare Provider Reimbursement Manual, publication HIM-15.
11. Discharge - The release of a patient from an acute care facility. The following patient situations are considered discharges under these rules.
 - a. The patient is formally released from the hospital.
 - b. The patient is transferred to a long-term care level or facility.
 - c. The patient dies while hospitalized.

amount will be prospectively set using the most current available base year data trended forward. Cost will be trended using the CMS Hospital Market Basket Forecast Rates. Payments will reflect changes from the base year to the payment period. For FFYs 2002 and 2003, the base year cost report used was FY 1999.

Effective for services provided on or after October 1, 2003, all public hospitals that qualify for the SC Medicaid DSH program will receive inpatient retrospective cost settlements. In calculating these settlements, allowable cost and payments will be calculated in accordance with the 100% UPL methodology defined in Section VIII of this Attachment.

Effective for services provided on or after October 1, 2003, all private (i.e. non-public) hospitals that qualify for the SC Medicaid DSH program will receive Medicaid inpatient retrospective cost settlements in accordance with 42 CFR 447.272. This settlement will be limited to ninety (90%) of the private DSH hospital's allowable Medicaid inpatient cost and will be calculated in accordance with the 100% UPL methodology defined in Section VIII of this Attachment.

Effective for services provided on or after July 1, 2004, qualifying hospitals that employ a burn intensive care unit will receive an annual retrospective cost settlement for inpatient services provided to South Carolina Medicaid patients. The qualification criteria allowing hospitals to receive this cost settlement is listed in Section II 4 of this Attachment. In calculating these cost settlements, allowable cost and payments will be calculated in accordance with the public hospital 100% UPL methodology defined in Section VIII of this Attachment.

P. Graduate Medical Education Payments for Managed Care Patients

For clarification purposes, the SCDHHS will pay teaching hospitals for SC Medicaid graduate medical education (GME) cost associated with SC Medicaid managed care patients. The managed care GME payment will be calculated the same as the medical education payment calculated by the fee-for-service program. It will be based on quarterly inpatient claim reports submitted by the managed care provider and the direct and/or indirect medical education add-on amounts that are paid to each hospital through the fee-for-service program. Payments will be made to the hospitals on a quarterly basis or less frequently depending on claims volume and the submission of the required data on the claim reports.

Q. Co-Payment

Effective January 1, 2004, a standard co-payment amount of \$25 per admission will be charged when a co-payment is applicable. The co-payment charged is in accordance with 42 CFR 447.53, 447.54(c) and 447.55.

SC: MA 04-006
EFFECTIVE DATE: 07/01/04
RO APPROVAL: OCT 12 2004
SUPERCEDES: MA 03-015

X. Review and Reporting Requirements

A. Utilization Review Specific to Prospective Payment

1. Utilization Review will be conducted by the state or its designee. Utilization review conducted by the designee will be performed as outlined in the current contract.
2. Negative review findings are subject to payment adjustment. Hospitals that develop or show trends in negative review findings will be subject to educational intervention.

B. Cost Report Requirements

Cost report requirements under the hospital prospective payment system will conform to Medicare cost reporting principles and use as their basis the Medicare Cost Report Form - CMS-2552. In addition, providers must comply with Medicaid specific cost report requirements as published by the DHHS.

1. Acute Care Hospitals

- a. All acute care hospitals contracting with the SC Medicaid program must submit the CMS-2552 cost report form within one hundred and fifty (150) days of the last day of their cost reporting period (or by the Medicare due date when an extension is granted by the Medicare program). Only hospitals with low utilization (less than 10 inpatient claims) will be exempt from this requirement.
- b. Cost report data may be used for future rate setting, cost settlements, cost analysis and disproportionate share purposes. Effective October 1, 1999, SC Department of Mental Health hospital cost reports will be used for annual retrospective cost settlements.

Effective for services provided on or after January 1, 2003, cost report data will be used to make retrospective inpatient cost settlements for public hospitals.

Effective for services provided on or after October 1, 2003, cost report data will be used to make retrospective inpatient cost settlements for public and private (i.e. non-public) hospitals that qualify for the SC Medicaid DSH program.

Effective for services provided on or after July 1, 2004, cost report data will be used to make annual retrospective inpatient cost settlements for qualifying hospitals that employ burn intensive care units.

- c. Medicaid inpatient capital cost will be retrospectively settled. Capital cost will be settled at 100% of total allowable Medicaid inpatient capital cost for service dates on or after October 1, 2000. In accordance with OBRA 1993 requirements, the upper payment limit for disproportionate share hospitals is 100% of their allowable cost. DSH payments will be taken into account in the capital cost settlement process. Effective for services provided on or after January 1, 2003, cost settlements for inpatient capital cost will only be necessary for non-public contracting hospitals.

Effective for services provided on or after October 1, 2003, cost settlements for inpatient capital cost will only be necessary for private (i.e. nonpublic) hospitals that do not qualify for the SC Medicaid DSH program. Private DSH hospitals will be limited to 90% of inpatient Medicaid allowable costs including capital.

SC: MA 04-006

EFFECTIVE DATE: 07/01/04

RO APPROVAL: OCT 12 2004

SUPERCEDES: MA 03-015

- d. Administrative days and associated cost, charges and payments will be reported on a supplemental worksheet issued by the DHHS. These days, cost, charges and payments must remain separate from all other Medicaid reported data. There will be no settlement for administrative days.

2. Psychiatric Residential Treatment Facilities

All psychiatric residential treatment facilities will submit the HCFA-2552 form as well as a certified audited financial statement. The HCFA-2552 will be completed using each facility's fiscal year statistical and financial information. Each facility will be required to submit these documents within one hundred and fifty (150) days of the last day of their cost reporting period.

C. Audit Requirements

All cost report financial and statistical information as well as the medical information contained on claims, is subject to audit by the DHHS or its designee. The audited information may be used for future rate calculations, inpatient capital and direct medical education cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

1. Desk audits of non-disproportionate share hospital cost reports.

- a. Cost reports of non-disproportionate share hospitals will be desk-audited in order to calculate capital cost settlements. Capital cost will be settled at 100% of total allowable Medicaid inpatient capital cost for service dates on or after October 1, 2000, and may be processed within 2 years after the end of a hospital's cost report period. Capital cost will be settled at 85% for service dates prior to October 1, 2000.
- b. Cost reports of hospitals with qualifying burn intensive care units will be desk audited in order to calculate annual retrospective cost settlements for services provided on or after July 1, 2004.

2. Supplemental worksheets submitted by hospitals qualifying for disproportionate share payments will be reviewed for accuracy. No additional payments will be made as a result of these reviews. Adjustments will be made only when reviews uncover overpayments or result in loss of disproportionate share status.

3. Medical audits will focus on the validity of diagnosis and procedure coding for reconciliation of appropriate expenditures made by the DHHS as described in A of this section.

4. Retrospective cost settlements will apply to RIFs as follows:

- a. There will be no retrospective cost settlement for psychiatric RIFs when audited base year cost data is used to set the reimbursement rate.
- b. There will be a retrospective cost adjustment for psychiatric RIFs when an interim rate is set on unaudited base year cost data. If the interim rate includes subsequent period add-ons, a retrospective cost adjustment will be performed on this subsequent period cost. Only recoupments resulting from negative adjustments will be allowed.
- c. There will be a retrospective cost settlement for state owned and operated psychiatric RIFs. These will be settled at 100% of allowable cost.
- d. There will be no retrospective cost adjustment for RIFs that are paid the statewide average rate.

SC: MA 04-006

EFFECTIVE DATE: 07/01/04

RO APPROVAL: OCT 12 2004

SUPERCEDES: MA 03-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE
(Reference Attachment 3.1-A)

2.a. OUTPATIENT HOSPITAL SERVICES

I. General ProvisionsA. Purpose and Upper Payment Limit (UPL)

This plan establishes the methods and standards for reimbursement of outpatient hospital services. The plan sets a prospective rate of payment which will not exceed the upper limit of payment for comparable services furnished under comparable circumstances under Medicare as required by 42 CFR 447.321.

1. Effective for services on or after October 1, 2003, public hospitals that qualify for the SC Medicaid DSH program will receive Medicaid outpatient retrospective cost settlements. Effective for services on or after October 1, 2003, private (i.e. non-public) hospitals that qualify for the SC Medicaid DSH program will receive Medicaid outpatient retrospective cost settlements that will be limited to 90% of their allowable Medicaid outpatient cost. The following methodology describes the cost settlement process for outpatient allowable cost.

Effective for services provided on or after July 1, 2004, qualifying hospitals that employ a burn intensive care unit will receive an annual retrospective cost settlement for outpatient services provided to SC Medicaid patients. The qualification criteria allowing hospitals to receive this cost settlement is listed in Section II 4 of Attachment 4.19-A. In calculating these cost settlements, allowable cost and payments will be calculated in accordance with the public hospital 100% UPL methodology defined below.

- a. Pending receipt of the cost report for the cost settlement period the base year cost report used for DSH payment purposes will be used to calculate an interim cost settlement. For FY 2004 the FY 2001 cost report will be used. Each public hospital's interim cost settlement will be equal to that hospital's trended allowable base year cost minus payments adjusted for new Medicaid revenue since the base year. Each private DSH hospital's interim cost settlement will be equal to 90% of that hospital's trended allowable base year cost minus payments adjusted for new Medicaid revenue since the base year. New Medicaid revenue will include any base rate increases since FY 2001 plus outpatient payment adjustments paid in addition to the claims payments (e.g. small hospital access payments).
- b. Trended allowable base year cost will be calculated using the following method. For FY 2004 each hospital's FY 2001 Medicaid outpatient allowable charges will be multiplied by the hospital's FY 2001 cost-to-charge ratio to determine the base year cost. This cost will be inflated from the base year to the payment period using the mid-year-to-mid-year inflation method and the CMS Market Basket Indices as described in Section VII.A.3. Public hospitals will receive 100% of their allowable Medicaid outpatient cost while private (i.e. non-public) DSH hospitals will receive 90% of their allowable Medicaid outpatient cost.

SC: MA 04-006

EFFECTIVE DATE: 7/01/04

RO APPROVAL: OCT 12 2004

SUPERCEDES: MA 03-015